



**AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

AKA: \_\_\_\_\_

Purpose of the Request or Disclosure:

Patient Care     Self     Legal     Provider Form     Other: \_\_\_\_\_

SEND TO     OBTAIN FROM

Name of Authorized Person or Facility: \_\_\_\_\_

Address of Person or Facility: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

I Authorize Release of the Following Records (check all that apply):

Medical Information     HIV & Related Information     STD     Substance Abuse     Mental Health

For Date of Service:

From: \_\_\_\_\_ To: \_\_\_\_\_ OR  ALL Records

Description of the Information to be Disclosed:

All Records

OR Specify: \_\_\_\_\_

*\*\*\*Please allow 7-14 business days for processing of all medical records requests. If your request is urgent, you must notify our office at the time of submission so we can review and determine if expedited processing is possible. Urgent requests are not guaranteed and will be handled on a case-by-case basis.*

Indicate how to release information:

Paper Copy     Fax     Email

Disclosure: Requests exceeding 10 pages may be processed through a third-party copy service and could incur additional fees.

**Authorization & Release:**

I authorize Metro Family Physicians Medical Group to release my medical records and release the practice from any liability related to this disclosure. This authorization is valid for 180 days from the date of signature and may be revoked at any time with oral or written notice; however, it does not apply to records already released. A photocopy of this authorization is as valid as the original. I understand that once records are released, they cannot be retrieved or controlled by the medical office

**Signature of Patient (or legal representative):** \_\_\_\_\_ Date \_\_\_\_\_ Time: \_\_\_\_\_

MUST HAVE WET SIGNATURE